CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Verification of Respiratory Care License

Use a separate form for each state in which you have ever been licensed to practice Respiratory Care. Forward to the other state jurisdiction(s) for their completion.

Name of Licensing Authority: _____	Applicant Name: _____
_____	Address: _____
Address: _____	City/State/Zip: _____
City/State/Zip: _____	

This section is to be completed by applicant.

Be sure to sign the form.

Last Name: _____ First Name: _____

SSN: _____ DOB: _____

Name if Different from Above: _____

I am applying for licensure as a Respiratory Care Practitioner in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the State of Delaware.

Signature: _____ Date: _____

To be completed by the Licensing Authority

Our records indicate that _____
(Type/print individual's name)

was licensed in the State/Province/Jurisdiction of _____, and was issued license

Number _____ on _____/_____/_____. Expiration Date: _____
Month Day Year

Has any discipline activity taken place regarding this application? Yes _____ No _____

If an action has been taken, please provide a certified copy of the Board Order when submitting this verification to the Delaware Board of Medical Practice.

Certification

*****AFFIX OFFICIAL SEAL HERE**

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name:_____ Signature:_____

Title:_____ Date of Signature: _____

Tel: _____ Fax: _____ E-mail: _____

*****RETURN COMPLETED FORM WITH <u>SEAL AFFIXED</u> TO THE BOARD ADDRESS ABOVE. THANK YOU.**